FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041509

Facility Name: HERITAGE MANOR-CARLINVILLE

Address: 1200 UNIVERSITY AVENUE (Number) CARLINVILLE (City) 61701 (Zip Code)

County: MACOUPIN

Telephone Number: (217) 854-4433 **Fax #** ( )

IDPA ID Number: 370909086006

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	85	Skilled (SNF)	85	31,110	1
2		Skilled Pediatric (SNF/PED)			2
3	23	Intermediate (ICF)	23	8,418	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,599	11,805	1,439	32,843	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	19,599	11,805	1,439	32,843	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 83.09%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 6 and days of care provided 1439

Medicare Intermediary MUTUAL OF OHMAHA

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	12704	12704	0
IPA	19599	19599	0
medicare	1439	1439	0
	33742	33742	

IPA BEDHOLDS	0
PP BEDHOLDS	795
PP CONVERS	104

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,087	10,665		139,752		139,752	2,624	142,376			1
2	Food Purchase		117,542		117,542		117,542	(588)	116,954			2
3	Housekeeping	89,320	13,332		102,652		102,652	0	102,652			3
4	Laundry	41,165	19,098		60,263		60,263	0	60,263			4
5	Heat and Other Utilities			98,638	98,638		98,638	914	99,552			5
6	Maintenance	26,892	37,507	22,012	86,411		86,411	9,284	95,695			6
7	Other (specify):*							0				7
8	TOTAL General Services	286,464	198,144	120,650	605,258		605,258	12,234	617,492			8
	B. Health Care and Programs											
9	Medical Director			1,695	1,695		1,695	0	1,695			9
10	Nursing and Medical Records	1,121,475	53,588	110,780	1,285,843		1,285,843	0	1,285,843			10
10a	Therapy		134,401	82,338	216,739	(312,703)	(95,964)	176,017	80,053			10a
11	Activities	43,624	1,039	0	44,663		44,663	0	44,663			11
12	Social Services	6,488	0	798	7,286		7,286	0	7,286			12
13	Nurse Aide Training	7,448	5,060		12,508		12,508	2,288	14,796			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	1,179,035	194,088	195,611	1,568,734	(312,703)	1,256,031	178,305	1,434,336			16
	C. General Administration											
17	Administrative	49,680			49,680		49,680	35,337	85,017			17
18	Directors Fees							2,681	2,681			18
19	Professional Services			257,765	257,765		257,765	(249,656)	8,109			19
20	Dues, Fees, Subscriptions & Promotions			71,866	71,866	(59,292)	12,574	(1,493)	11,081			20
21	Clerical & General Office Expense	113,304	7,845	15,385	136,534		136,534	130,707	267,241			21
22	Employee Benefits & Payroll Taxes			258,054	258,054		258,054	20,613	278,667			22
23	Inservice Training & Education			981	981		981	977	1,958			23
24	Travel and Seminar			7,834	7,834		7,834	(5,835)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			10,356	10,356		10,356	1,259	11,615			26
27	Other (specify):*			13,912	13,912		13,912	(13,912)				27
28	TOTAL General Administration	162,984	7,845	636,153	806,982	(59,292)	747,690	(79,322)	668,368			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,628,483	400,077	952,414	2,980,974	(371,995)	2,608,979	111,217	2,720,196			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			137,413	137,413		137,413	6,335	143,748			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			286,555	286,555		286,555	(857)	285,698			32
33	Real Estate Taxes			28,390	28,390		28,390	0	28,390			33
34	Rent-Facility & Grounds			0				7,721	7,721			34
35	Rent-Equipment & Vehicles			4,088	4,088		4,088	16,201	20,289			35
36	Other (specify):*							0				36
37	TOTAL Ownership			456,446	456,446		456,446	29,400	485,846			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					312,703	312,703	0	312,703			39
40	Barber and Beauty Shops	0	437	10,345	10,782		10,782	0	10,782			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					59,292	59,292	0	59,292			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		437	10,345	10,782	371,995	382,777		382,777			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,628,483	400,514	1,419,205	3,448,202	0	3,448,202	140,617	3,588,819			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	0	35		5
6	Rented Facility Space	(9)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(75)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(588)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,547)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,985)	24		19
20	Contributions	(52)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(615)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,860)	27		24
25	Fund Raising, Advertising and Promotional	(3,352)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	0	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,083)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	172,700		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 172,700		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 140,617		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name HERITAGE MANOR-CARLINVILLE

IDH 0041509

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
	The information listed in B13 thru G43 is from Page 5.		
1	**Day Care**	0	0
2	**Other Cars for Outpatients**	0	0
3	**Governmental Sponsored Special Programs**	0	0
4	**Non-Patient Meals**	0	0
5	**Telephone, TV & Radio in Resident Rooms**	0	35
6	**Rented Facility Space**	(9)	34
7	**Sale of Supplies to Non-Patients**	0	
8	**Laundry for Non-Patients**	0	
9	**Non-Straightline Depreciation**	0	30
10	**Interest and Other Investment Income**	(75)	32
11	**Discounts, Allowances, Rebates & Refunds**	0	
12	**Non-Working Officer's or Owner's Salary**	0	
13	**Sales Tax**	(588)	2
14	**Non-Care Related Interest**	0	32
15	**Non-Care Related Owner's Transactions**	0	
16	**Personal Expenses (Including Transportation)**	0	24
17	**Non-Care Related Fees**	(1,547)	20
18	**Fines and Penalties**	0	
19	**Entertainment**	(11,985)	24
20	**Contributions**	(52)	27
21	**Owner or Key-Man Insurance**	0	
22	**Special Legal Fees & Legal Retainers**	(615)	19
23	**Malpractice Insurance for Individuals**	0	
24	**Bad Debt**	(11,860)	27
25	**Fund Raising, Advertising and Promotional**	(3,352)	20
26	**Income & IL Personal Property Replacement T**	0	0
27	**Nurse Aide Training for Non-Employees**	0	0
28	**Yellow Page Advertising**	0	0
29	**Non-Paid Workers**	0	0
30	**Donated Goods**	0	0
31	**Amortization Expense**	0	0
32		0	

Sch V Line	Adj. Summary
Line 1	0
Line 2	(588)
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	(615)
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	(814)
Line 20	(4,899)
Line 21	0
Line 22	0
Line 23	0
Line 24	(11,860)
Line 25	0
Line 26	0
Line 27	(13,911)
Line 28	(31,417)
Line 29	(11,860)
Line 30	0
Line 31	0
Line 32	(83)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(86)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(52,699)

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,624	0	0	0	0	0	0	0	0	2,624	1
2	Food Purchase	(588)	0		0	0	0	0	0	0	0	0	(588)	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	914	0	0	0	0	0	0	0	0	914	5
6	Maintenance	0	0	9,284	0	0	0	0	0	0	0	0	9,284	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(588)	0	12,822	0	0	0	0	0	0	0	0	12,234	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	1,082		0	174,935	0	0	0	0	0	0	176,017	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,288	0	0	0	0	0	0	0	0	2,288	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1,082	2,288	0	174,935	0	0	0	0	0	0	178,305	16
	C. General Administration													
17	Administrative	0	0	35,337	0	0	0	0	0	0	0	0	35,337	17
18	Directors Fees	0	0	2,681	0	0	0	0	0	0	0	0	2,681	18
19	Professional Services	(615)	0	8,109	0	(257,150)	0	0	0	0	0	0	(249,656)	19
20	Fees, Subscriptions & Promotions	(4,899)	0	3,406	0	0	0	0	0	0	0	0	(1,493)	20
21	Clerical & General Office Expenses	0	0	130,707	0	0	0	0	0	0	0	0	130,707	21
22	Employee Benefits & Payroll Taxes	0	0	20,613	0	0	0	0	0	0	0	0	20,613	22
23	Inservice Training & Education	0	0	977	0	0	0	0	0	0	0	0	977	23
24	Travel and Seminar	(11,985)	0	6,150	0	0	0	0	0	0	0	0	(5,835)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,259	0	0	0	0	0	0	0	0	1,259	26
27	Other (specify):*	(13,912)	0	0	0	0	0	0	0	0	0	0	(13,912)	27
28	**TOTAL General Administration**	(31,411)	0	209,239	0	(257,150)	0	0	0	0	0	0	(79,322)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,999)	1,082	224,349	0	(82,215)	0	0	0	0	0	0	111,217	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	6,335	0	0	0	0	0	0	0	6,335	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	(75)	0	0	(782)	0	0	0	0	0	0	0	(857)	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(9)	0	0	7,730	0	0	0	0	0	0	0	7,721	34
35	Rent-Equipment & Vehicles	0	0	0	16,201	0	0	0	0	0	0	0	16,201	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(84)	0	0	29,484	0	0	0	0	0	0	0	29,400	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(32,083)	1,082	224,349	29,484	(82,215)	0	0	0	0	0	0	140,617	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-CARLINVILLI # 0041509 Report Period Beginning 01/01/00 Ending 12/31/00

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							1
2	V	10a Adjustment for Related Organizati	77,876	GreenTree Therapy	100.000%	78,958	1,082	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 77,876			$ 78,958	$ * 1,082	14

Sum_6

1082

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 2,624	$ 2,624	15	2624
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				914	914	19	914
20	V	6	Maintenance				9,284	9,284	20	9284
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				2,288	2,288	26	2288
27	V	14	Program Transportatior				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				35,337	35,337	29	35337
30	V	18	Directors Fees				2,681	2,681	30	2681
31	V	19	Professional Services				8,109	8,109	31	8109
32	V	20	Fees, Subscription, Promotion				3,406	3,406	32	3406
33	V	21	Clerical & General Office Expenses				130,707	130,707	33	130707
34	V	22	Employee Benefits & Payroll Taxes				20,613	20,613	34	20613
35	V	23	Inservice Training & Education				977	977	35	977
36	V	24	Travel and Seminar				6,150	6,150	36	6150
37	V	25	Other Admin. Staff Transportatior				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,259	1,259	38	1259
39	Total			$			$ 224,349	$ * 224,349	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6B
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V		30	Depreciation				6,335	6,335	16	6335
17	V		31	Amortization of Pre-Op & Org				0		17	
18	V		32	Interest				(782)	(782)	18	-782
19	V		33	Real Estate Taxes				0		19	
20	V		34	Rent-Facility & Grounds				7,730	7,730	20	7730
21	V		35	Rent-Equipment & Vehicles				16,201	16,201	21	16201
22	V		36	Other				0		22	
23	V		38	Medically Nec Transportation				0		23	
24	V		39	Ancillary Service Centers				0		24	
25	V		40	Barber and Beauty Shops				0		25	
26	V		41	Coffee and Gift Shops				0		26	
27	V		42	Other				0		27	
28	V									28	
29	V									29	
30	V									30	
31	V									31	
32	V									32	
33	V									33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	Total				$			$ 29,484	$ * 29,484	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organizatio	$ 257,150	Heritage Enterprises, Inc.		$	$ (257,150)	15	-257150
16	V								16	
17	V	10a	Adjustment for Related Organizatior	132,859	Green Tree Pharmacy	100.00%	307,794	174,935	17	174935
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 390,009			$ 307,794	$ * (82,215)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Boarc	Management	0.26	18,337	10	0.20	Directors Fe	$ 893	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	0.10	18,336	10	0.20	Directors Fees	894	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	0.20	18,336	10	0.20	Directors Fees	894	line 18, col 7	3
4	Bill Froelich	Chairman of Boarc	Management	0.26	131,110	10	0.20	Salary	6,390	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	0.10	131,110	10	0.20	Salary	6,390	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	0.20	108,575	10	0.20	Salary	5,292	line 17, col 7	6
7	Joe Warner	President	Management	0.03	102,469	48	0.95	Salary	4,994	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.01	66,763	50	1.00	Salary	3,254	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.00	54,999	50	1.00	Salary	2,680	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.00	54,721	50	1.00	Salary	2,667	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	33,781	40	1.00	Salary	1,646	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	41,529	50	1.00	Salary	2,024	line 17, col 7	12
13								TOTAL	$ 38,018		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,324	23	$ 56,457	$ 56,457	108	$ 2,624	1
2	2	Food Purchase	BEDS	2,324	23	6	0	108	0	2
3	3	Housekeeping	BEDS	2,324	23	0	0	108	0	3
4	4	Laundry	BEDS	2,324	23	0	0	108	0	4
5	5	Heat & Other Utilities	BEDS	2,324	23	19,665	0	108	914	5
6	6	Maintenance	BEDS	2,324	23	199,772	50,885	108	9,284	6
7	7	Other	BEDS	2,324	23	0	0	108	0	7
8	9	Medical Director	BEDS	2,324	23	0	0	108	0	8
9	10	Nursing & Medical Records	BEDS	2,324	23	0	0	108	0	9
10	11	Activities	BEDS	2,324	23	0	0	108	0	10
11	12	Social Service	BEDS	2,324	23	0	0	108	0	11
12	13	Nurse Aide Training	BEDS	2,324	23	49,237	43,081	108	2,288	12
13	14	Program Transportation	BEDS	2,324	23	0	0	108	0	13
14	15	Other	BEDS	2,324	23	0	0	108	0	14
15	17	Administrative	BEDS	2,324	23	760,393	760,393	108	35,337	15
16	18	Directors Fees	BEDS	2,324	23	57,693	0	108	2,681	16
17	19	Professional Services	BEDS	2,324	23	174,483	0	108	8,109	17
18	20	Fees, Subscription, Promotion	BEDS	2,324	23	73,288	0	108	3,406	18
19	21	Clerical & General Office Exp	BEDS	2,324	23	2,812,617	2,533,181	108	130,707	19
20	22	Employee Benefits & Payroll	BEDS	2,324	23	443,562	0	108	20,613	20
21	23	Inservice Training & Educati	BEDS	2,324	23	21,017	0	108	977	21
22	24	Travel and Seminar	BEDS	2,324	23	132,330	0	108	6,150	22
23	25	Other Admin. Staff Transpor	BEDS	2,324	23	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,324	23	27,096	0	108	1,259	24
25	TOTALS					$ 4,827,616	$ 3,443,997		$ 224,349	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,324	23	$ 0	$ 0	108	$ 0	1
2	30	Depreciation	BEDS	2,324	23	136,322	0	108	6,335	2
3	31	Amortization of Pre-Op & Or	BEDS	2,324	23	0	0	108	0	3
4	32	Interest	BEDS	2,324	23	(16,821)	0	108	(782)	4
5	33	Real Estate Taxes	BEDS	2,324	23	0	0	108	0	5
6	34	Rent-Facility & Grounds	BEDS	2,324	23	166,328	0	108	7,730	6
7	35	Rent-Equipment & Vehicles	BEDS	2,324	23	348,617	0	108	16,201	7
8	36	Other	BEDS	2,324	23	0	0	108	0	8
9	38	Medically Nec Transportation	BEDS	2,324	23	0	0	108	0	9
10	39	Ancillary Service Centers	BEDS	2,324	23	0	0	108	0	10
11	40	Barber and Beauty Shops	BEDS	2,324	23	0	0	108	0	11
12	41	Coffee and Gift Shops	BEDS	2,324	23	0	0	108	0	12
13	42	Other	BEDS	2,324	23	0	0	108	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,446	$		$ 29,484	25

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City		XX	Mortage	$28,143.00	03/01/96	$ 3,385,859	$ 2,986,120	03/01/06	0.079	$ 240,010	1
2	National City Loan Amortization		XX	Mortgage							3,060	2
3	Central Office Allocation		XX	Interest Income							(782)	3
4	Donald Barry		xx			03/01/96	188,103	103,095	03/01/01	Variable	10,309	4
5												5
	Working Capital											
6												6
7	National City working Capital										33,176	7
8												8
9	TOTAL Facility Related				$28,143.00		$ 3,573,962	$ 3,089,215			$ 285,773	9
	B. Non-Facility Related*											
10	Interest Income										(75)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,573,962	$ 3,089,215			$ 285,698	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	34,128	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,496	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,632)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	32,022	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	28,390	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,411	8
	1996	53,400	9
	1997	58,759	10
	1998	57,580	11
	1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		03/01/96	$ 32,017	1
2	Nursing Home				2
3	TOTALS			$ 32,017	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108				$ 3,265,145	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heritage Manor Sign			1996	2,176						9
10	Architect Fees			1996	2,387						10
11	Laundry Room Electrical Repair			1996	3,019						11
12											12
13											13
14	Special Care Unit -- Remodel			1997	30,884						14
15											15
16	Remodel-- Alzheimer Wing			1998	78,813						16
17	A/C Unit			1998	950						17
18	Life Safety Improvements			1998	7,351						18
19	Shower Room Remodel			1998	2,811						19
20	Roof Replacement			1998	92,246						20
21											21
22	Door Alarm			1999	2,317						22
23	Smoke Damperer			1999	498						23
24	Water System			1999	8,115						24
25	Interior Painting--Material and Labor			1999	6,892						25
26	Shower Room Remodel			1999	2,453						26
27	Water Heater			1999	4,253						27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							6,335	6,335		34
35	Book Depreciation					88,374		88,374		409,792	35
36	TOTAL (lines 4 thru 35)				$ 3510310	$ 88,374		$ 94,709	$ 6,335	$ 409,792	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Water Softener			2000	3,802						9
10	Shower room Remodel ---Material and Labor			2000	3,608						10
11	A/C Rooftop Unit			2000	12,490						11
12	Pipe --Hallway Floor			2000	1,920						12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 320,238	$ 49,039	$ 49,039	$		$ 210,812	37
38	Current Year Purchases	20,547						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 340,785	$ 49,039	$ 49,039	$		$ 210,812	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 137,413	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 143,748	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 6,335	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 620,604	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 0			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 0
13.	/2002	$ 0
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 20,289 Description: Copier, Cell Phone and Central Office Allocation
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		5,060		5,060
3	Classroom Wages (a)		7,448		7,448
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,288		2,288
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 14,796	$	$ 14,796
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,796			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$	1,311	$ 33,416	$	1,311	$ 33,416	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs		285	13,142		285	13,142	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs		1,363	32,400	1,095	1,363	33,495	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				308,241		308,241	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				4,462			4,462	13
14	TOTAL			$	2,959	$ 83,420	$ 309,336	2,959	$ 392,756	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -3456
st adj 5648
Ot adj -1110

drugs 174935

Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 362	$	1
2	Cash-Patient Deposits	5,312		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	258,295		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,114		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,185,494)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (906,411)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,017		13
14	Buildings, at Historical Cost	3,532,131		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	340,785		16
17	Accumulated Depreciation (book methods)	(620,604)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	15,660		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,299,989	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,393,578	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,716	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,312		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,833		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,438		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,022		32
33	Accrued Interest Payable	23,244		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 249,565	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,089,215		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,089,215	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,338,780	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (945,202)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,393,578	$	48

***(See instructions.)**

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (729,782)	1
2	Restatements (describe):		2
3	audit Adjustment	(10,275)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (740,057)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(205,145)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (205,145)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (945,202)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,121,151	1
2	Discounts and Allowances for all Levels	(297,888)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,823,263	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	140,815	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 140,815	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	28,603	11
12	Gift and Coffee Shop	3,796	12
13	Barber and Beauty Care	14,542	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	9	16
17	Sale of Drugs	231,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 278,904	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	75	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 75	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	other	0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,243,057	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 605,258	31
32	Health Care	1,568,734	32
33	General Administration	806,982	33
	B. Capital Expense		
34	Ownership	456,446	34
	C. Ancillary Expense		
35	Special Cost Centers	10,782	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		0	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,448,202	40
41	**Income before Income Taxes (line 30 minus line 40)****	(205,145)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (205,145)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number HERITAGE MANOR-CARLINVILLE # 0041509 Report Period Beginning 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,935	2,053	$ 38,960	$ 18.98	1
2	Assistant Director of Nursing	1,879	1,886	29,415	15.60	2
3	Registered Nurses	6,614	7,150	120,595	16.87	3
4	Licensed Practical Nurses	16,859	18,552	251,205	13.54	4
5	Nurse Aides & Orderlies	77,615	81,387	667,358	8.20	5
6	Nurse Aide Trainees	961	961	7,448	7.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,620	1,742	13,942	8.00	8
9	Activity Director					9
10	Activity Assistants	5,626	5,963	43,624	7.32	10
11	Social Service Workers	517	738	6,488	8.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,860	17,932	129,087	7.20	15
16	Dishwashers					16
17	Maintenance Workers	2,324	2,581	26,892	10.42	17
18	Housekeepers	13,097	13,957	89,320	6.40	18
19	Laundry	6,328	6,482	41,165	6.35	19
20	Administrator	2,080	2,080	49,680	23.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,047	10,912	113,304	10.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,362	174,376	$ 1,628,483 *	$ 9.34	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		1,695		36
37	Medical Records Consultant		706		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,166		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		798		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,365		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 13,871		50
51	Licensed Practical Nurses		66,363		51
52	Nurse Aides		23,106		52
53	TOTAL (lines 50 - 52)		$ 103,340		53

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